Potential Role for Value-Based Insurance Design in Specialty Pharmaceuticals

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Improving Care and Bending the Cost Curve  
Shifting the discussion from “How much” to “How well”

• Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality.

• Regardless of these advances, cost growth is the principle focus of health care reform discussions.

• Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the entire spectrum of clinical care.

• Attention should turn from how much to how well we spend our health care dollars.
Role of Consumer Cost-Sharing in Medical Decisions

- For today’s discussion, our focus is on costs paid by the consumer, not the employer or third party administrator.
- Ideally consumer cost-sharing levels would be set to encourage the clinically appropriate use of healthcare services.
- Instead, archaic “one-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions.
- Consumer cost-sharing is rising.

Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

Barbara Fendrick (my mother)
Impact of Increases in Consumer Cost-Sharing on Health Care Utilization

A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential care, which worsens health disparities, and in some cases leads to greater overall costs.

Cost-sharing Affects Mammography Use by Medicare Beneficiaries

Trivedi A. NEJM. 2008;358:375-383
High Copays Reduce Adherence to Appropriate Medication Use

Change in Days Supplied for Selected Drug Classes When Copays Were Doubled

- Diabetes: -25%
- High Cholesterol: -34%
- Hypertension: -26%

- When copays were doubled, patients took less medication in important classes. These reductions in medication levels were profound.
- Reductions in medications supplied were also noted for:
  - NSAIDs 45%
  - Antihistamines 44%
  - Antiulcerants 33%
  - Antiasthmatics 32%
  - Antidepressants 26%
- For patients taking medications for asthma, diabetes, and gastric disorders, there was a 17% increase in annual ER visits and a 10% increase in hospital stays.

ER = emergency room.

Medication Affordability Attributable to Medicare Part D Implementation

- A recent *Health Affairs* article investigated whether the gains in affordability for prescription drugs attributable to Part D persisted during the six years that followed its implementation in 2006.

- Among elderly beneficiaries with four or more chronic conditions, the prevalence of cost-related non-adherence increased from 14% in 2009 to 17% in 2011, reversing previous downward trends.

- The prevalence among the sickest elderly of forgoing basic needs to purchase medicines decreased from 9% in 2007 to 7% in 2009 but rose to 10% in 2011.
Effects of Increased Copayments for Ambulatory Visits for Medicare Advantage Beneficiaries

Copays increased:

- from $7.38 to $14.38 for primary care
- from $12.66 to $22.05 for specialty care
- remained unchanged at $8.33 and $11.38 in controls

In the year after copayment increases:

- 19.8 fewer annual outpatient visits per 100 enrollees
- 2.2 additional hospital admissions per 100 enrollees
- Effects worse in low-income individuals and beneficiaries with chronic illness

By WILLIAM M. BULKELEY

In an unusual bid to cut health-care costs, International Business Machines Corp. plans to stop requiring $20 co-payments by employees when they visit primary-care physicians.

The company said it believed the move would save costs by encouraging people to go to primary-care doctors faster, in order to get earlier diagnoses that could save on expensive visits to specialists and emergency rooms.

IBM said that the action applies to the 80% of its workers who are enrolled in plans in which the company self-insures—that is, programs in which it pays the health-care benefits, not insurers. The new policy doesn’t cover IBM employees in health-maintenance organizations.

One of the nation’s largest employers with 115,000 U.S. workers, IBM spends about $1.3 billion a year on U.S. health care. Its benefit practices are closely watched in the human-resources community, and its actions are sometimes trend-setters.
Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.

Solutions Needed to Curb Cost-related Non-adherence

• These findings highlight the need for targeted efforts to alleviate the persistent issue of cost-related non-adherence
A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:
   - Who receives it
   - Who provides it
   - Where it's provided
Implementing Clinical Nuance Value-Based Insurance Design

• Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service – Reduce or eliminate financial barriers to high-value clinical services and providers

• Successfully implemented by hundreds of public and private payers
Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- Most V-BID programs focus on removing financial barriers to high-value prescription drugs to treat chronic conditions (e.g., diabetes, asthma, heart disease)

- Evidence review
  - Improved adherence
  - Lower consumer out-of-pocket costs
  - No significant increase in total spending
  - Reduction in health disparities

By Niteesh K. Choudhry, Katsiaryna Bykova, William H. Shrank, Michele Tescaro, Wayne S. Rawlins, Lanny Pelowitz, Troyen A. Brennan, and Jessica M. Franklin

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

ABSTRACT Substantial racial and ethnic disparities in cardiovascular care persist in the United States. For example, African Americans and Hispanics with cardiovascular disease are 10–40 percent less likely than whites to receive secondary prevention therapies, such as aspirin and beta-blockers. Lowering copayments for these therapies improves outcomes among all patients who have had a myocardial infarction, but the impact of lower copayments on health disparities is unknown. Using self-reported race and ethnicity for participants in the Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we found that rates of medication adherence were significantly lower and rates of adverse clinical outcomes were significantly higher for nonwhite patients than for white patients. Providing full drug coverage increased medication adherence in both groups. Among nonwhite patients, it also reduced the rates of major vascular events or revascularization by 35 percent and reduced total health care spending by 70 percent. Providing full coverage had no effect on clinical outcomes and costs for white patients. We conclude that lowering copayments for medications after myocardial infarctions may reduce racial and ethnic disparities for cardiovascular disease.

Emerging Best Practices in V-BID Implementation

A 2014 Health Affairs evaluation of 76 V-BID plans reported that programs that:

• were more generous
• targeted high-risk individuals
• offered wellness programs
• avoided disease management
• used mail-order prescriptions

had greater impact on adherence than plans without these features.

Choudhry, N. Health Affairs. 2014;33(3).
MI-FREEE: Better Quality Without Higher Costs

- Assessed impact of free access to preventive medications for Aetna members with history of MI
- Random assignment by plan sponsor
- “Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs.”

Evidence for Value-Based Insurance Design: Reducing Health Care Disparities

Full drug coverage:

- Reduced rates of a post-MI vascular event or revascularization among patients who self-identified as being non-white

- Reduced total health care spending by 70 percent among patients who self-identified as being non-white

Health Aff (Millwood). 2014 May;33(5):863-70
Multi-Stakeholder Support for V-BID

- HHS - National Quality Strategy
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Partnership for Sustainable Health Care
- National Governor’s Assoc.
- Academy of Actuaries
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM – Essential Health Benefits
Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)

Over 100 million Americans have received expanded coverage of preventive services
The Value-Based Insurance Design for Better Care Act of 2014

To establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures.

IN THE HOUSE OF REPRESENTATIVES

Mrs. BLACK (for herself and Mr. BLUMENAUER) introduced the following bill; which was referred to the Committee on ____________________

Sponsored by:
Value-Based Insurance Design
Growing Role in State Health Reform

• State Employees Benefit Plans
  - Connecticut
  - Oregon
  - Virginia
  - Minnesota
  - Maine

• State Exchanges
  - Maryland
  - California

• CO-OPs

• Medicaid
Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- Participating employees receive a reprieve from higher premiums if they commit to:
  - Yearly physicals, age-appropriate screenings/preventive care, two free dental cleanings
  - If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)

- Early results:
  - 99% of employees enrolled and 99% compliant
  - Decrease in ER and specialty care
  - Increase in primary care visits
  - Increase in chronic disease medication adherence
CMS Rules (CMS-2334-F) Enable V-BID in Medicaid

- Plans may vary cost-sharing for drugs, outpatient, inpatient, and emergency department visits

- Plans may target cost-sharing to specific groups of individuals based on clinical information (e.g., diagnosis, risk factors)

- Plans may vary cost-sharing for an outpatient service according to where and by whom the service is provided
Value-Based Insurance Design
More than High-Value Drugs for Chronic Conditions

- Prevention/Screening
- Diagnostic tests/Monitoring
- Treatments
- Clinician visits
- Physician networks
- Hospitals
- Role in specialty pharmaceuticals
Specialty medicines are prescription drugs that require special handling/administration and/or a higher level of patient care management ... and high cost!
Advances in Biotechnology

- The following 3 categories account for more than half of all spend:
  - Cancer
  - Rheumatoid Arthritis
  - Multiple Sclerosis
- Approximately 50%-60% of specialty drugs are represented by the oncology category

Source: PRDMA.org 2013 Report
Trends & Opportunities

**Pipeline**
- 600+ drugs in the pipeline over the next 5–8 years
- Oncology represents about 45% of the pipeline
- 35% of oncology and 64% of non-oncology may be self-administered

**Biosimilars**
- 46 biotech products with patent expirations through 2020*
- $31.5 billion biosimilar opportunity
- Interchangeable alternatives will greatly affect management options and cost

**Medical vs. Prescription**
- Significant amount of specialty drug spend is on the medical benefit
- Frequently administered in high cost places of treatment
- Limited ability to apply critical health and safety checks

**Bioethics**
- Specialty pipeline will continue to produce high-cost drugs
- Growing impact on the viability of Benefit Plans
- Question of coverage for a small number of high cost patients vs. the whole patient population
The ability to manage total Specialty pharmacy care and spend will become increasingly important for clients.
Top ranking pharma issues that dominated the news, 2005 - 2013

- Others
- Healthcare Reform
- Medicare/Medicaid Coverage for Drugs
- Flu Vaccines
- Genomics and Biologics
- Bioterrorism
- Marketing/Sales Incentives
- DTC Advertising
- Developing Countries
- Generics
- Clinical Study Designs and Sponsorship
- Data Disclosure
- R&D for New Drugs
- Interaction with the FDA
- Drug Safety
- High Drug Prices in the US
CUT PRICES ON DRUGS.

ARRANGING TO CARRY THE CONFLICT INTO THE COURTS.

Economical Company Will Endeavor to Prove That the Retailers and the Wholesalers in the City Have Entered Into a Conspiracy to Drive It Out of Business—The Regular Dealers Accused of Extortion—What Suburban Apothecaries Have to Say of the War.

The determination of the Economical Drug company to carry the drug war to the courts and determine whether or not it has a right to conduct a store at a reasonable rate of profit, even though it conflicts with the usual prac-
DRUG PRICES SOAR

Morphine Going Up $1 Per Ounce a Day and Quinine Follows

In the last two weeks there has been a big jump in the price of drugs, and, as regards opiates, which are practically a necessity in medical practice, a shortage exists which seems critical.

Morphine and codeine, which are derived from opium, can be purchased only in small quantities, and the prices asked are almost fabulous. Quotations on these drugs in the last two weeks have increased at the rate almost of $1 per ounce a day, wholesale, and to the consumer, of course, the price is much higher. The quotations, good only for the day, are $21. Two weeks ago the drugs were selling at $14.

The reasons given for the phenomenal rise are the failure of the opium crop in India, and the great demand for these drugs because of the war. No new opium is coming into the country, and there will soon be a shortage that will make the drug as precious as any jewel.

Quicksilver, which in normal times is quoted from $3 to $5, is now $150 per 5 pound flask. Permanganate of potash, a disinfectant, is now $1.20 a pound; before the war it was 12 cents a pound. As this comes principally from Germany, the high price is easily explained.

Quinine is 50 percent higher, and continues to go up. Camphor is 50 percent higher than two years ago.
Americans, World’s No. 1 Pill Takers, Feel They Pay Too Much for Drugs

By Roger D. Greene
Associated Press

Americans are the world’s greatest pill takers. They pay nearly $50 million a year to swallow about 53 million aspirin a day. They gulp nearly $230 million worth of vitamin capsules annually.

They order almost 400 million prescriptions a year at a cost of nearly a billion dollars. That’s a big bill. So big, in fact, that a great many Americans are complaining about its size.

Surveys show that from 64 to 71 per cent of all drug customers think they’re paying too much for the products they buy.

Example, they point to the fact that six companies gambled millions of dollars to mass produce a polio vaccine before they knew the result of mass tests.

Because of such expensive activities, the industry contends, today’s prescription dollar is worth more than ever.

$10 a Year-Per Capita

Theodore G. Lumpp, president of the National Pharmaceutical Council, says the average per capita cost of drugs is about $10 a year, compared with $55 for alcoholic beverages, $32 for tobacco and $11 for auto repairs.

Is the duggist getting rich?

A survey by Eli Lilly & Co., one of the leading United States drug manufacturing firms, noted that the average retail druggist has an income of $12,825 a year. But he usually works long hours, including Sundays and holidays.

By comparison, the United States Department of Commerce says the average physician has an income of $12,518, the average lawyer $9,375 and the dentist $7,743.

With the drug industry growing swiftly, the agency is having trouble keeping up with the demand. Larrick says, adding: “We have
LONG PLANS INQUIRY ON PRICING OF DRUGS

WASHINGTON, July 23 (AP) — Senator Russell B. Long said today he was planning an investigation of drug prices and Federal health programs.
Applying V-BID to Specialty Pharmaceuticals Approaches

• Impose no more than modest cost-sharing on high-value services

• Reduce cost-sharing in accordance with patient- or disease-specific characteristics

• Relieve patients from high cost-sharing if clinical goals not achieved on a different medication “reward the good soldier”

• Use cost-sharing to encourage patients to select high-performing providers and settings
Improving Care and Bending the Cost Curve

• The ultimate test of health reform will be whether it improves health and addresses rising costs

• V-BID should be part of the solution to improve quality and enhance the efficiency of health care Medicare spending

Discussion

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